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Testimony of Sheldon Toubman in Support of SB 407, An Act Concerning A Hospital Quality Of Care Initiative, with Proposed Amendment to Provide Consumer Input

Good afternoon, Senator Slossberg, Rep. Abercrombie, and members of the Human Services Committee. My name is Sheldon Toubman and I am an attorney specializing in the representation of Medicaid applicants and enrollees. I am here to testify in support of SB 407, which holds the promise of improving the quality of care for vulnerable Medicaid enrollees, but without the dangers inherent in imposing financial risk on providers, which is the alternative approach being pursued by many. With additional language to ensure that the program of hospital discharge care management is developed with consumer input and monitoring, under the Council on Medical Assistance Program Oversight (MAPOC), I support this proposal.

Although our Medicaid program has a long way to go, it has been substantially improved in the last two years, largely because of the leadership of the Malloy Administration and the legislature in recognizing that imposing financial risk on insurers as the means of delivering health care to low income Medicaid enrollees was just not working—for the enrollees, their providers or the taxpayers. On January 1, 2012, the program moved from capitated, risk-based managed care to an innovative system where providers are paid directly by the state for providing services, plus additional payments for care coordination through patient-centered medical homes (PCMHs) and financial rewards for providers who perform well on quality measures. And the entire system is support by a non-risk, non-profit administrative services organization (ASO), providing intensive care management in many cases. Not coincidentally, while almost all other states are seeing substantial increases in their Medicaid costs, our Medicaid program is seeing **lower** costs per person, while quality has improved. For one thing, emergency room visits have dropped, a sure sign of better coordination of care.

While Connecticut should be congratulated on its success to date, more needs to be done to expand the use of medical homes and coordinate care. SB 407 can help in this regard by improving the quality of hospital-based care and the establishment of good follow-up care, in those cases where hospitalization cannot be avoided. Having hospitals work with DSS and its ASO contractor to promote effective discharge planning and robust community-based follow up should be a win for both Medicaid enrollees and the taxpayers, as hospital readmissions are avoided.

I also note, critically, what SB-407 does NOT include: It does not impose direct financial incentives for the hospitals to save money on the total cost of care, such as under the controversial State Innovation Model (or SIM) proposal now being developed by the administration. Under SIM, primary care providers will be paid extra if they are able to reduce the total cost of care for their patients (shared savings). While some have argued that imposing such incentives will encourage primary care providers to be more efficient in the provision of care and avoid redundant or unnecessary care, such financial incentives can just as easily result in denials of **appropriate** care, particularly expensive appropriate

care provided by others, as the means to save money. Although there is an intention to monitor for resulting under-service, it is unclear if the measures of under-service will be in place before financial incentives to save money are imposed (at least outside of the Medicaid program). This would not be necessary without the problematic incentive system. Thus, the SIM plan has the potential for savings money but at the cost of restricting access to appropriate care.

Also, the SIM plan has had no public hearing by the legislature or any other body (there was one event where, late in the process, individuals were invited to a forum, but with very limited time for the public to comment; many individuals present were not allowed to speak). And this is despite the fact that the greatest concern about SIM, acknowledged in the final SIM plan, is that, because it does impose direct financial incentives for providers to save money on their patients' total cost of care, the proposed shared savings payment model could cause denials of appropriate care for patients, under all payer systems (not just Medicaid).

SB 407 does not go down that troubling route. You are holding a public hearing today on this proposal. And the proposal seeks to improve the quality of care by directly incentivizing it, rather than merely hoping it will result if a financial incentive to save money on patients' total cost of care is imposed. It also will engage providers in partnership with consumers, in the pursuit of improvements in the quality of care. Although the incentives in SB 407, unlike under SIM, are not tied directly to saving money, as our recent experience with PCMH plus a non-risk ASO in Medicaid demonstrates, such quality-based incentives, if properly implemented, also can save money for the taxpayers.

Nevertheless, the "Inpatient discharge care management program" in SB 407 could be implemented in ways which could be harmful if DSS used this program to aggressively move individuals out of hospitals prematurely, as private insurers have been known to use their hospital-based representatives to do. Although the hospitals would not be financially incentivized to move people out early, they would be rewarded for running a program which could allow DSS/CHN to do so. It is therefore critical that there be consumer input in both the design of this program and its monitoring. The best place for that resides with the Complex Care Committee of the MAPOC, about half of whose members are independent consumer advocates. This committee is charged with oversight over the Medicaid program to the extent it provides care to medically complex individuals—the very individuals whom the discharge care management program is designed to target (those at "high risk for readmission"). And it has discharged that responsibility well, for example, in the case of the duals demonstration model (disclosure: I am on this committee).

Accordingly, I strongly recommend that the definition of the "Inpatient discharge care management program" in Section 1(a)(7) of the bill be amended to add this language:

> "This program shall be developed by the department with input from, and oversight by, the Council on Medical Assistance Program Oversight and its Complex Care Committee."

With the amendment I have proposed to ensure consumer oversight of the program, I urge you to pass favorably on SB 407.

Thank you for the opportunity to speak with you today.